		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038372

Facility Name: Heartland Christian Village

Address: 101 Trowbridge (Number) Neoga (City) 62447 (Zip Code)

County: Cumberland

Telephone Number: 217-895-2665 **Fax #** ( )

IDPA ID Number: 37-0841562009

Date of Initial License for Current Owners: 10/12/1995

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2003 to June 30, 2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Richard A. Walbert
(Title) Vice President of Finance

Paid Preparer
(Signed) (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	16	Sheltered Care (SC)	9	3,285	5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,688	5,497	2,367	15,552	8
9	SNF/PED					9
10	ICF	3,617	1,527		5,144	10
11	ICF/DD					11
12	SC	565	2,383		2,948	12
13	DD 16 OR LESS					13
14	TOTALS	11,870	9,407	2,367	23,644	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.24%

D. How many bed-hold days during this year were paid by Public Aid?
125 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/12/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/12/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 62 and days of care provided 2,367

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heartland Christian Village # 0038372 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	114,673	13,857	4,957	133,487		133,487		133,487			1
2	Food Purchase		114,165		114,165		114,165	(471)	113,694			2
3	Housekeeping	92,351	15,964		108,315		108,315		108,315			3
4	Laundry											4
5	Heat and Other Utilities			83,198	83,198		83,198	1,381	84,579			5
6	Maintenance	33,651	10,528	12,130	56,309		56,309	6,309	62,618			6
7	Other (specify):*											7
8	**TOTAL General Services**	240,675	154,514	100,285	495,474		495,474	7,219	502,693			8
	B. Health Care and Programs											
9	Medical Director			3,809	3,809		3,809		3,809			9
10	Nursing and Medical Records	970,887	117,445	7,821	1,096,153		1,096,153		1,096,153			10
10a	Therapy			165,128	165,128		165,128		165,128			10a
11	Activities	28,145			28,145		28,145		28,145			11
12	Social Services	37,200	2,024	3,119	42,343		42,343	(649)	41,694			12
13	Nurse Aide Training											13
14	Program Transportation			661	661		661		661			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,036,232	119,469	180,538	1,336,239		1,336,239	(649)	1,335,590			16
	C. General Administration											
17	Administrative	62,940		167,208	230,148		230,148	(124,494)	105,654			17
18	Directors Fees											18
19	Professional Services			1,888	1,888		1,888	5,128	7,016			19
20	Dues, Fees, Subscriptions & Promotions			20,974	20,974		20,974	(9,064)	11,910			20
21	Clerical & General Office Expenses	50,526	3,370	64,567	118,463		118,463	22,677	141,140			21
22	Employee Benefits & Payroll Taxes			270,406	270,406		270,406	16,681	287,087			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,353	8,353		8,353	6,996	15,349			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,096	61,096		61,096	677	61,773			26
27	Other (specify):*											27
28	**TOTAL General Administration**	113,466	3,370	594,492	711,328		711,328	(81,399)	629,929			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,390,373	277,353	875,315	2,543,041		2,543,041	(74,829)	2,468,212			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Christian Village #0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			98,790	98,790	(68)	98,722	10,194	108,916			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			330,496	330,496		330,496	(1,869)	328,627			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Def Bond Cost**			1,922	1,922		1,922		1,922			36
37	**TOTAL Ownership**			431,208	431,208	(68)	431,140	8,325	439,465			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,053	7,053		7,053		7,053			39
40	Barber and Beauty Shops	12,120	725		12,845		12,845		12,845			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,038	34,038		34,038		34,038			42
43	Other (specify):* **Apt/Cong**			73,575	73,575	68	73,643	(37,130)	36,513			43
44	**TOTAL Special Cost Centers**	12,120	725	114,666	127,511	68	127,579	(37,130)	90,449			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,402,493	278,078	1,421,189	3,101,760		3,101,760	(103,634)	2,998,126			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(953)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,425)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,761)	32		10
11	Discounts, Allowances, Rebates & Refunds	196	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(37,130)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,451)	21		24
25	Fund Raising, Advertising and Promotional	(214)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(7,225)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (85,963)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(17,671)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (17,671)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (103,634)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heartland Christian Village

ID# 0038372

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous	$ (100)	17	1
2	Vending	482	2	2
3	Activity	(649)	12	3
4	Exempt Interest Income - Endowment	1,892	32	4
5	Marketing	(8,850)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,225)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(471)	0	0	0	0	0	0	0	0	0	0	(471)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,425)	5,806	0	0	0	0	0	0	0	0	0	1,381	5
6	Maintenance	0	6,309	0	0	0	0	0	0	0	0	0	6,309	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,896)	12,115	0	0	0	0	0	0	0	0	0	7,219	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(649)	0	0	0	0	0	0	0	0	0	0	(649)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(649)	0	0	0	0	0	0	0	0	0	0	(649)	16
	C. General Administration													
17	Administrative	(100)	(124,394)	0	0	0	0	0	0	0	0	0	(124,494)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,128	0	0	0	0	0	0	0	0	0	5,128	19
20	Fees, Subscriptions & Promotions	(9,064)	0	0	0	0	0	0	0	0	0	0	(9,064)	20
21	Clerical & General Office Expenses	(32,255)	54,932	0	0	0	0	0	0	0	0	0	22,677	21
22	Employee Benefits & Payroll Taxes	0	16,681	0	0	0	0	0	0	0	0	0	16,681	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,996	0	0	0	0	0	0	0	0	0	6,996	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	677	0	0	0	0	0	0	0	0	0	677	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(41,419)	(39,980)	0	0	0	0	0	0	0	0	0	(81,399)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,964)	(27,865)	0	0	0	0	0	0	0	0	0	(74,829)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Heartland Christian Village** **#** **0038372** **Report Period Beginning:** **July 1, 2003** **Ending:** **June 30, 2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	10,194	0	0	0	0	0	0	0	0	0	10,194	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,869)	0	0	0	0	0	0	0	0	0	0	(1,869)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,869)	10,194	0	0	0	0	0	0	0	0	0	8,325	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(37,130)	0	0	0	0	0	0	0	0	0	0	(37,130)	43
44	**TOTAL Special Cost Centers**	(37,130)	0	0	0	0	0	0	0	0	0	0	(37,130)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(85,963)	(17,671)	0	0	0	0	0	0	0	0	0	(103,634)	45

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc	100.00%	$ 5,806	$ 5,806	1
2	V	6	Maintenance				6,309	6,309	2
3	V	17	Administration	167,208			42,814	(124,394)	3
4	V	19	Professional Services				5,128	5,128	4
5	V	21	Clerical				54,932	54,932	5
6	V	22	Employee Benefits				16,681	16,681	6
7	V	24	Travel & Seminar				6,996	6,996	7
8	V	26	Insurance				677	677	8
9	V	30	Depreciation				10,194	10,194	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 167,208			$ 149,537	$ * (17,671)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: ne 30, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		x	Bldg & Equipment	$23,650.00	05/01/91	$ 2,508,000	$ 1,350,394	04/15/01	0.0725	$ 103,325	1
2	Revenue Bonds 1993-A(60%)	x		Bldg & Equipment	$13,331.00	01/01/93	1,100,000	849,150	01/01/18	0.0650	55,695	2
3	Revenue Bonds 1996-A	x		Redeem Debt	$3,481.00	07/01/96	450,000	388,950	07/01/21	0.0700	27,502	3
4	Revenue Bonds 1997-A	x		Redeem Debt	$5,533.00	01/01/97	720,000	630,720	01/01/22	0.0700	44,566	4
5												5
	Working Capital											
6	CHI Bond Fund Payable	x		Working Capital				265,271		0.0850	22,880	6
7	Revenue Bonds 2001-Y	x		Redeem Debt	$5,833.00	10/01/01	1,000,000	1,000,000	10/01/31	0.0700	70,000	7
8	Bond Financing Fees										6,528	8
9	TOTAL Facility Related				$51,828.00		$ 5,778,000	$ 4,484,485			$ 330,496	9
	B. Non-Facility Related*											
10	Revenue Bonds 1993-A(40%)	x		Bldg. & Equipment	$4,667.00	01/01/93	700,000	566,100	01/01/18	0.0650	37,130	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$4,667.00		$ 700,000	$ 566,100			$ 37,130	14
15	TOTALS (line 9+line14)						$ 6,478,000	$ 5,050,585			$ 367,626	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heartland Christian Village # 0038372 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Christian Village COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0038372

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		This workpaper is not applicable.	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,980 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,980	Various	$ 41,767	1
2	Home Office Allocation			4,411	2
3	TOTALS	29,980		$ 46,178	3

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71		1992	1992	$ 2,601,099	$ 65,028	40	$ 65,028	$	$ 764,072	4
5			1995	1995	119,926	2,998	40	2,998		27,981	5
6											6
7											7
8	Home Office Allocation				35,092	1,017		1,017		17,087	8
	Improvement Type**										
9	Carpeting			1992	9,961		5			9,961	9
10	Wallcoverings			1992	8,385		5			8,385	10
11	Wallcoverings			1992	16,128		5			16,128	11
12	Fire Alarm Commtctor			1992	578	29	20	29		341	12
13	Towel Rings			1992	637		10			637	13
14	Rail & Gate Loading			1993	536		10			536	14
15	Door Lock			1993	856	32	10	32		856	15
16	Autodoor			1994	908	91	10	91		887	16
17	Blank										17
18	Electric Work - Fire Alarm			1998	1,335	134	10	134		826	18
19	Smoke Dampers			1998	2,284	228	10	228		1,425	19
20	Water Heater			2000	5,831	583	10	583		2,672	20
21	Expansion Tank			2000	1,126	225	5	225		1,031	21
22	Ceiling Fans (2) Activity			2000	500	100	5	100		450	22
23	Floor Covering-Assisted Living Area			12/18/2001	1,161	232	5	232		599	23
24	Trane A/C Unit			6/11/2002	1,370	137	10	137		285	24
25	Friedrich 14400 BTU PTAC Unit			9/5/2002	699	87	8	87		160	25
26	Carpet - Rooms 102,104,105 & 116			92302	942	188	5	188		345	26
27	Roof-NH Maintenance Garage			12/13/2002	1,500	300	5	300		475	27
28	Carpet - Rooms 110,111 & 113			12/2/2002	922	184	5	184		291	28
29	Water Heater			1/26/2003	3,788	379	10	379		569	29
30	Mixing Valve/Plumbing System			6/18/2003	2,330	233	10	233		252	30
31	Sewer lines			10/13/1992	37,086	927	40	927		10,892	31
32	Patio & Sidewalks			10/13/1992	900	45	20	45		529	32
33	Sign			10/13/1992	6,286		10			6,286	33
34	Landscaping			10/13/1992	21,485	1,074	20	1,074		12,620	34
35	Landscaping			7/3/1995	2,602		5			2,602	35
36	Sidewalk			11/25/1998	1,405	94	5	94		1,405	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flagpole light at entrance	6/17/2003	$ 793	$ 79	10	$ 79	$	$ 86	37
38	Friedrich 14400 BTU PTAC Unit	7/15/2003	698	87	8	87		87	38
39	Carpeting - Rooms #101 & 105	7/23/2003	567	113	5	113		113	39
40	Install Exhaust Fan - O2 Room	2/11/2004	532	44	5	44		44	40
41	Friedrich 14400 BTU PTAC Unit	1/29/2004	648	41	8	41		41	41
42	Elemco/Opto Energy Management System	2/16/2004	5,676	237	10	237		237	42
43	Friedrich 14400 BTU PTAC Unit	5/24/2004	701	15	8	15		15	43
44	A/C Unit for Office	6/10/2004	1,400	12	10	12		12	44
45	Floor Tile - Kitchen	6/10/2004	617		5				45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,899,290	$ 74,973		$ 74,973	$	$ 891,220	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 216,873	$ 21,336	$ 21,336	$		$ 141,025	71
72	Current Year Purchases	26,032	1,382	1,382			1,382	72
73	Fully Depreciated Assets	188,062					188,062	73
74	Home Office Allocation	56,393	7,510	7,510			25,474	74
75	TOTALS	$ 487,360	$ 30,228	$ 30,228	$		$ 355,943	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1994 Ford Bus	1994	$ 42,670	$	$	$	8	$ 42,670	76
77	Patient Transportation	1993 Chevy Van w/lift	1996	16,383	2,048	2,048		8	15,872	77
78										78
79	Home Office Allocation			6,844	1,667	1,667			4,173	79
80	TOTALS			$ 65,897	$ 3,715	$ 3,715	$		$ 62,715	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,498,725	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,916	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 108,916	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,309,878	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Duplex Land	$ 41,767	$	$	86
87	Duplex Land Improvements	65,202	2,359	28,947	87
88	Duplex Buildings	642,229	18,193	227,406	88
89	Duplex Equipment	16,983	335	14,767	89
90	Carport	895	68	68	90
91	TOTALS	$ 767,076	$ 20,955	$ 271,188	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heartland Christian Village # 0038372 **Report Period Beginning:** July 1, 2003 **Ending:** June 30, 2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 360,119	$	1
2	Cash-Patient Deposits	14,283		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 45,624)	270,024		3
4	Supply Inventory (priced at FIFO)	20,045		4
5	Short-Term Investments	19,595		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Acc. Int. Rec./Other A/R	523		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 684,589	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,534		13
14	Buildings, at Historical Cost	3,436,764		14
15	Leasehold Improvements, at Historical Cost	135,758		15
16	Equipment, at Historical Cost	507,003		16
17	Accumulated Depreciation (book methods)	(1,534,332)		17
18	Deferred Charges	13,292		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	110,932		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,752,951	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,437,540	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 54,161	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,283		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,680		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,079		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Apartment Revenue	16,429		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 229,632	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,350,394		40
41	Bonds Payable	3,700,191		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,050,585	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,280,217	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,842,677)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,437,540	$	48

***(See instructions.)**

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,983,074)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,983,074)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(9,603)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (9,603)	17
	B. Transfers (Itemize):		
18	**Transfer In from Affiliate**	150,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 150,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,842,677)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,140,998	1
2	Discounts and Allowances for all Levels	(460,769)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,680,229	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	294,931	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 294,931	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,554	13
14	Non-Patient Meals	953	14
15	Telephone, Television and Radio	7,240	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,121	19
20	Radiology and X-Ray	1,540	20
21	Other Medical Services	71	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,479	23
	D. Non-Operating Revenue		
24	Contributions	31,632	24
25	Interest and Other Investment Income***	3,761	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35,393	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investments/Equip Disposal	(2,404)	28
28a	Apt/Cong	53,529	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,125	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,092,157	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	495,474	31
32	Health Care	1,336,239	32
33	General Administration	711,328	33
	B. Capital Expense		
34	Ownership	431,208	34
	C. Ancillary Expense		
35	Special Cost Centers	93,473	35
36	Provider Participation Fee	34,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,101,760	40
41	**Income before Income Taxes (line 30 minus line 40)****	(9,603)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (9,603)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,546	1,931	$ 38,317	$ 19.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,690	3,634	94,795	26.09	3
4	Licensed Practical Nurses	19,070	19,665	337,560	17.17	4
5	Nurse Aides & Orderlies	41,197	42,305	454,533	10.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,256	4,379	45,682	10.43	8
9	Activity Director	1,740	1,772	15,891	8.97	9
10	Activity Assistants	1,477	1,502	12,254	8.16	10
11	Social Service Workers	2,886	2,955	37,200	12.59	11
12	Dietician					12
13	Food Service Supervisor	1,755	1,862	22,880	12.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,585	11,013	91,793	8.33	15
16	Dishwashers					16
17	Maintenance Workers	1,860	2,245	33,651	14.99	17
18	Housekeepers	10,447	10,775	92,351	8.57	18
19	Laundry					19
20	Administrator	1,630	1,871	62,940	33.64	20
21	Assistant Administrator					21
22	Other Administrative	1,079	1,136	14,644	12.89	22
23	Office Manager	1,889	2,003	29,827	14.89	23
24	Clerical	490	517	6,055	11.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,100	1,111	12,120	10.91	33
34	TOTAL (lines 1 - 33)	105,697	110,676	$ 1,402,493 *	$ 12.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	124	$ 4,959	1.3	35
36	Medical Director	208	3,809	9.3	36
37	Medical Records Consultant	23	1,125	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	2,237	10.3	39
40	Physical Therapy Consultant	1,344	82,690	10A.3	40
41	Occupational Therapy Consultant	1,069	63,294	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	340	18,994	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	47	3,119	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,239	$ 180,227		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John I.M. Letizia	Administrator	0	$ 62,940
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 62,940

B. Administrative - Other

Description	Amount
Management Expense	$ 167,208
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 167,208

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 37
Van Ostrand	Legal	1,851
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 1,888

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,384
Unemployment Compensation Insurance	7,200
FICA Taxes	103,872
Employee Health Insurance	104,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	9,602
Employee Physicals	3,348
Home Office Allocation	16,681
TOTAL (agree to Schedule V, line 22, col.8)	$ 287,087

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,343
Health Care Worker Background Check (Indicate # of checks performed)	
Subscriptions	290
Dues	2,269
Software support & Updates	5,680
Remote fee	28
Miscellaneous	300
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,910

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 14
In-State Travel	6,620
Miscellaneous	149
Seminar Expense	1,570
Home Office Allocation	6,996
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,349

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland Christian Village # 0038372 Report Period Beginning: July 1, 2003 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $ 1827**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,741** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **34,038**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **953**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Heartland Christian Village
Allocation on Benefits 6/30/2004 kdb
11/3/2005

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	Benefit Percentage	Employee Uniforms	W C Med Expense	Employee Expense	Employee Physicals	
7,862.47	276.00	1,644.00	9,600.00		-1,158.58		10,760.21	3,348.00	
2,426.67	144.00	852.00	4,800.00						
8,203.12	816.00	4,848.00	10,800.00						270,405.60
6,318.83	660.00	3,876.00	7,600.00						
73,356.19	4,776.00	28,104.00	66,000.00						
4,760.68	456.00	2,664.00	5,200.00						
944.01	72.00	396.00							
103,871.97	7,200.00	42,384.00	104,000.00	0.00	-1,158.58	0.00	10,760.21	3,348.00	270,405.60

Less Benefits: 0.00
Line 3.22.3 270,405.60

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Heart Land Christian Village
Staffiing and Salary Costs

sms
06/30/04 11/03/05

Description	Line Number	Salary	% of Benefits	Benefits	Total Salary
Director of Nursing	20.1	37,153.06	3.95%	1,164.11	38,317.17
Assist. DON	20.2	0.00	0.00%	0.00	0.00
Registered Nurses	20.3	91,915.02	9.76%	2,879.96	94,794.98
Licensed Practical Nurses	20.4	327,304.36	34.77%	10,255.38	337,559.74
Nurses Aides & Orderlies	20.5	440,723.92	46.82%	13,809.13	454,533.05
Rehab/Therapy Aides	20.8	44,294.08	4.71%	1,387.86	45,681.94
	Total	941,390.44	100.00%	29,496.44	970,886.88

		Benefits	29,496.44				
		20.1	20.2	20.3	20.4	20.5	20.8
		37,153.06		8,468.45	8,978.73	22,132.67	44,294.08
				19,556.47	89,265.23	11,352.22	
				43,581.01	38,854.75	248,061.92	
				389.70	128,055.51	131,456.89	
				13,523.97	43,099.97	64.65	
				143.77	18,704.21	27,253.23	
				6,251.65	345.96	402.34	
	Totals	37,153.06	0.00	91,915.02	327,304.36	440,723.92	44,294.08

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